SENT VIA EMAIL OR FAX ON
Mar/19/2010

Applied Assessments LLC

An Independent Review Organization
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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:
Mar/18/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
MRI Cervical; MRI Right Shoulder

DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:
Doctor of Medicine (M.D.)
Board Certified in Orthopaedic Surgery
Fellowship Training in Upper Extremities

REVIEW OUTCOME:

Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

[X] Upheld (Agree)

[ ] Overturned (Disagree)

[ ] Partially Overturned (Agree in part/Disagree in part)

INFORMATION PROVIDED TO THE IRO FOR REVIEW
OD Guidelines
Denial Letters 1/28/10 and 2/11/10
Bone & Joint 7/30/09 thru 2/25/10
MRI 8/4/09

PATIENT CLINICAL HISTORY SUMMARY
The patient has continued pain in the shoulder as well as neck pain that radiates to the hand 6 months status post mini open rotator cuff repair. The patient has limited range of motion in the shoulder and has also been given a diagnosis of adhesive capsulitis. The medical records provided do not document a thorough neurological examination. Range of motion of the shoulder is limited. Supraspinatus strength is not recorded well.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDING CLINICAL BASIS, FINDINGS

AND CONCLUSIONS USED TO SUPPORT THE DECISION

Although further imaging may be necessary in this patient, the medical records provided to not adequately document the patient's physical examination. Therefore, based on the medical records, the request for MRI of the shoulder and MRI of the cervical spine is not medically reasonable or necessary. In addition, there are other paths forward, that would be more appropriate to further evaluate the rotator cuff repair. Based on the current level of documentation by the surgeon, and requests for shoulder and cervical MRI scans are not reasonable or necessary.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION

[ ] ACOEM-AMERICA COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE

[ ] AHCPR-AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES

[ ] DWC-DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES

[ ] EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN

[ ] INTERQUAL CRITERIA

[X] MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

[ ] MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

[ ] MILLIMAN CARE GUIDELINES

[X] ODG-OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES

[ ] PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR

[ ] TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS

[ ] TEXAS TACADA GUIDELINES

[ ] TMF SCREENING CRITERIA MANUAL

[ ] PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)

[ ] OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)